

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health



Health Regulation
& Licensing Administration



SENT via FACSIMILE and US MAIL

January 15, 2008

Ron Raghunandan
CEO/CFO
Individual Development, Inc.
1420 N Street, NW Suite 9
Washington, DC 20005

RE: 6520 First Street, NW

Dear Mr. Raghunandan:

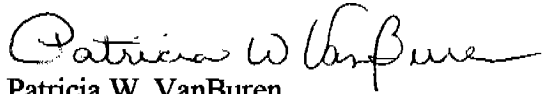
You will find enclosed a Statement of Deficiencies reports for federal certification and licensure. The reports enumerate deficiencies found as a result of the survey conducted on **December 20, 2007**. You are required to respond to each deficiency. Although a reasonable period of time may be allowed for actual correction of these deficiencies, it is imperative that your plan be signed with a specific date for anticipated completion and returned to this office prior to **January 25, 2008**. Since these reports are subject to public disclosure, it is necessary that the responses be indicated on the original forms (and not on an attachment, except if submitting a copy of a policy change). NOTE: "Corrected" is not an accepted reply. The plan MUST also include the following.

- **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**
- **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**
- **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and**
- **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented.**

PLEASE NOTE: Plans of Correction not adhering to the above requirements will not be considered acceptable. Also, failure to submit acceptable plans, within the specified time frame, MAY result in the loss of Medicaid reimbursement.

If you have any questions or concerns regarding the above, please contact Ms. Sheila Pannell, Supervisory Health Service Program Specialist, Intermediate Care Facilities Division on (202) 442-5888.

Sincerely,

A handwritten signature in cursive script, reading "Patricia W. VanBuren".

Patricia W. VanBuren
Program Manager

Enclosures

cc: Medical Assistance Administration
Department on Disability Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS A recertification survey was conducted from December 18, 2007 through December 20, 2007. The survey was initiated using the fundamental survey process. A random sample of three clients were selected from a population of six females with various degrees of disabilities. The findings of this survey were based on observations at the group home, two day programs, interviews with clients and staff at both the group home and day programs, review of clinical and administrative records to include the facility's unusual incident reports.	W 000			
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that outside services met the needs for one of the two clients in the sample. (Client #2). The findings include: 1. Review of Client #2's clinical records at the day program on December 18, 2007 at 11:20 AM revealed an Individual Support Plan (ISP) dated November 1, 2006. Interview with the Day Program Case Manager indicated that the day program had not yet received the new ISP. However, an ISP meeting was held in early November 2007. Further interview with the Developmental Disability Services (DDS) Case Manager indicated that the ISP had not yet been	W 120			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 120	Continued From page 1 approved. After the DDS Case Manager approves the ISP, she would then forward the ISP to the day program. 2. Review of Client #2's clinical records from the day program on December 18, 2007 at 11:20 AM revealed incidents of finger bending, screaming and skin pinching. Interview with the day program staff revealed that the client displays maladaptive behaviors of finger bending. Further interview revealed that the day program staff were baselining these maladaptive behaviors. The baseline behaviors began documentation since June 2006. According to the DDS Case Manager on December 20, 2007, she was not aware that the day program had not developed and implemented the Behavior Support Plan as recommended at the annual ISP meeting dated November 7, 2007.	W 120			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for one of the three clients in the sample. (Client #2) The findings include:	W 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 124	Continued From page 2 On December 18, 2007 at 6:15 PM, Client #2 was observed during the evening medication pass being administered Revia 50 mg and Zyprexa 15 mg. Interview with the Licensed Practical Nurse (LPN) at approximately 6:40 PM revealed that client was prescribed these medications for behavioral management. Review of Client #2's current physician's orders confirmed that the client was prescribed the aforementioned medication. Further interview with the LPN revealed that the medications were incorporated into the client's Behavior Support Plan (BSP) dated December 1, 2007 to address targeted behaviors that included self-injurious behaviors (finger bending), screaming and trichotillomania. Interview with the LPN during the entrance conference on December 18, 2007 at 9:15 AM revealed that Client #2's cousin is very involved in his life but is not the client's legal guardians. Review of the client's, psychological assessment on December 20, 2007 revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility obtained consent from Client #2's cousin of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124			
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's	W 148			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 148	<p>Continued From page 3</p> <p>parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents or guardians of significant incidents for one of the three clients included in the sample. (Clients #2)</p> <p>The findings include:</p> <p>Review of the facility's unusual incident reports and investigations on December 18, 2007 at approximately 9:35 AM, revealed evidence that the facility failed to notify family members immediately of the following significant incidents:</p> <p>a. On April 11, 2007, Client #2 was taken to the local emergency room for shortness of breath. The client was admitted and discharged on May 2, 2007.</p> <p>b. On March 17, 2007, the direct care staff discovered a "red and dark spot" on Client #2's left heel during evening shower. The nurse assessed the client and there were no distress noted.</p> <p>c. On February 22, 2007, Client #2 was taken to the local emergency room for shortness of breath. The client was admitted and discharged on February 27, 2007.</p>	W 148			
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written</p>	W 149			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 149	Continued From page 4 policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement or establish a policy to report all of significant health changes to the State Agency as required by 22 DCMR 35. The findings include: Review of the incident reports on December 18, 2007 beginning at 9:35 AM, the facility failed to ensure that all emergency room visits were reported to the Department of Health as evidence below: a. On April 11, 2007, Client #2 was taken to the local emergency room for shortness of breath. The client was admitted and discharged on May 2, 2007. b. On February 22, 2007, Client #2 was taken to the local emergency room for shortness of breath. The client was admitted and discharged on February 27, 2007.	W 149			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by:	W 153			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 153	<p>Continued From page 5</p> <p>Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) one of the three clients included in the sample. (Client #2)</p> <p>The findings include:</p> <p>Review of the incident reports on December 18, 2007 beginning at 9:35 AM revealed the following incidents had not been reported to the State Agency as required:</p> <p>a. On April 11, 2007, Client #2 was taken to the local emergency room for shortness of breath. The client was admitted and discharged on May 2, 2007.</p> <p>b. On March 17, 2007, the direct care staff discovered a "red and dark spot" on Client #2's left heel during evening shower. The nurse assessed the client and there were no distress noted.</p> <p>c. On February 22, 2007, Client #2 was taken to the local emergency room for shortness of breath. The client was admitted and discharged on February 27, 2007.</p>	W 153			
W 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interview and record</p>	W 192			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 192	<p>Continued From page 6</p> <p>review, the facility failed to effectively implement adaptive equipment during the medication pass and feeding protocols protocols for three of the three clients in the sample. (Clients #1, #2 and #3)</p> <p>The findings include:</p> <p>The facility failed to implement feeding protocols for two of the three clients in the sample. (Clients #1 and #2)</p> <p>a. On December 18, 2007 at approximately 5:10 PM, Client #1 was observed being fed by direct care staff. The direct care staff interchangeable feeding the client food and liquids during the meal. The client coughed during the meal. The Feeding Protocol dated September 12, 2007 instructed the direct care staff, "Do not offer beverages until after meal completion."</p> <p>b. On December 18, 2007 during the dinner observation, Client #2 was observed receiving her meal and after the client completed her meal, the direct care staff gave the client her liquids which included water and juice. Interview with the direct care staff indicated that the client, Consumes all of her liquids at one time," and therefore her liquids were provided after the client completions her meal. Review of the client's Feeding Protocol dated November 4, 2007 required the staff to encourage sips of beverage between bites and after meals.</p> <p>2. The facility's nurse failed to use the recommended adaptive equipment for Client #3 as evidenced by the following:</p> <p>During the dinner observation on December 18,</p>	W 192			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 192	Continued From page 7 2007 at 5:10 PM, Client #3 used a spout cup to drink her beverage. During the medication pass observation conducted on December 18, 2007 at 7:19 PM, the nurse administered medications to the client. After the client took the medication, the nurse gave the client water in a regular plastic cup. After all of the water was consumed from the plastic cup, the client asked for more water and the nurse gave her water in her spout cup. Review of the client's Individual Support Plan (ISP) dated March 7, 2007, revealed that the client was required to use a spout cup for consuming liquids.	W 192			
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that assessments to determine the presenting problems were conducted for two of the three clients in the sample. (Clients #2 and #3) The findings include: 1. The facility failed to assess Client #2 to determine her need to participate in a self medication program. On December 18, 2007 at 6:15 PM, the medication nurse was observed administering Client #2's medications. During observations throughout the survey from December 18 - 20, 2007, Client #2 was observed to pour water with staff assistance and feeding herself. Interview	W 212			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 212	Continued From page 8 with the licensed practical nurse indicated that the client did not participate in a self medication training program. Review of the medical record revealed no self medication assessment. 2. The facility failed to ensure that the self medication assessment accurately describes the clients capabilities as evidenced below: During the medication pass observation conducted on on December 18, 2007, at 7:19 PM, Client #3 was administered her medication by mouth. During the dinner observation, Client #3 ate her dinner without assistance and without any coughing or signs of aspiration. Review of the Self Medication Assessment dated March 6, 2007 indicated the following: "all meds to be administered via G-tube." Interview with the facility's nurse on December 18, 2007 revealed that the physician indicated that the client could receive her medications by mouth but if she refused them, the medication could be given via the G-tube. There was no evidence that the client had been re-assessed by the nursing staff nor had the client's self-medication assessment been updated to reflect the clients ability to accept her medications per mouth.	W 212			
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to implement a system that provided an opportunity for clients' choices and self management for one of three clients in the	W 247			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 247	Continued From page 9 sample (Client #3). The finding includes: On December 18, 2007, the direct care staff informed Client #3 what food items were on the dinner menu. Client #3 expressed her dislike for the intended food and indicated what she would like for dinner. The staff prepared White Castle cheeseburger, macaroni salad in substitution for the pork ribs and colelaw. On the next day, December 19, 2007, staff prepared Client #3's lunch which consisted of the identical food items that were served during dinner. (White Castle cheeseburger and macaroni salad). The staff, did not offer Client #3 a choice of what she wanted. This observation was brought to the attention of the Qualified Mental Retardation Professional (QMRP) and the Facility Coordinator who indicated that the client liked to eat the cheeseburgers. They also indicated that often times and that the staff had to substitute menu items to accommodate Client #3's liked and dislikes. The QMRP and Facility Coordinator indicated that Client #3's preferences had been assessed by the nutritionist, but it was unclear if the client's preferences were incorporated into the menu. Also there was no evidence that the nutritionist was aware of the substitution frequency or the client's food preferences.	W 247			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number	W 249			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	<p>Continued From page 10</p> <p>and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to provide continuous active treatment for one of the three clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>1. During the entrance conference on December 18, 2007 at 9:15 AM with the Licensed Practical Nurse (LPN) revealed that Client #2 attends day program, part time (Monday, Wednesday and Fridays). On December 18, 2007 between 4:00 PM and 6:00 PM, the client walked around the facility two times. On December 20, 2007 from 9:00 AM through 1:00 PM, Client #2 was observed in her bedroom (in the bed or wheelchair) participating in active treatment of self stimulatory activities.</p> <p>Interview with the direct care staff on December 19, 2007 at approximately 11:00 AM indicated that the client had a walking program to increase endurance. Review of the client's Individual Program Plan (IPP) dated November 7, 2007 revealed an objective which stated, "[the client] will ambulate two trips around the interior of the house every hour between 7 AM - 8 PM on an ongoing basis. There was no evidence that the facility implemented Client #2's walking program as indicated.</p> <p>2. On December 18, 2007 at 5:20 PM, after</p>	W 249			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	<p>Continued From page 11</p> <p>Client #2 completed her dinner meal, the client was observed to remove her dinner plate and cup from the table and put on the kitchen counter with direct care staff encouragement. The direct care staff wiped the dining room table down. Interview with the direct care staff indicated that the client enjoyed assisting the staff. Review of the client's IPP dated November 7, 2007 revealed a program objective which stated, "Given verbal directives, [the client] will clean her areas of the table after dinner on 80% of the trials recorded per month for six consecutive months by November 2008". According to the data sheet, the steps consisted of collecting plate and utensils, taking them to kitchen, collecting paper towels, wiping the table and trashing the paper towel. The direct care staff did not encourage the client to complete all the steps to complete the task.</p> <p>3. On December 18, 2007 at approximately 4:30 PM, the direct care staff was observed preparing dinner which consisted of baked beans, coleslaw and ribs. At 4:50 PM, Client #2 was escorted by staff to the kitchen to assist with dinner preparations. Once in the kitchen, the client assisted direct care staff with pouring water into cups.</p> <p>Interview with the direct care staff indicated that the Client #2 liked to assist with dinner preparations (making salad). Review of the clients IPP dated November 7, 2007 revealed a program objective which stated, "Given verbal directives, [the client] will assist by preparing vegetable salad during dinner meal on 80% of the trials recorded per month for six consecutive month by November 2008". Further interview with the the direct care staff indicated that when a salad was not on the menu, the client would "just"</p>	W 249			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	Continued From page 12 assist in the kitchen. It should be noted that the data sheet indicated that the program objective should be implement and documented five times per week (Monday - Friday). There was no evidence that the facility implemented Client #2's program as indicated.	W 249			
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client had successfully completed an objective identified in the IPP for one of the three clients in the sample. (Client #1) The finding includes: The facility's QMRP failed to revise Client #1's program objectives. Client #1's IPP dated march 7, 2007 was reviewed on December 19, 2007 at approximately 1:30 PM. The client had a program objective which stated, "Given hand over hand assistance, [the client] will activate a tape recorded (low tech device) in response to query with 70% accuracy per session for three consecutive months as measured by active treatment documentation.	W 255			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 255	Continued From page 13	W 255			
W 262	<p>Record verification of the data sheets indicated that the client achieved the established criteria in July 2007.</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>This STANDARD is not met as evidenced by: Client #2's seatbelt fastening in the rear.</p> <p>Based on observation, staff interview, and record review, the facility's Human Rights Committee (HRC) failed to review and approve the use of restrictive measures, for one of the three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Observations during the medication administration on December 18, 2007 at 6:15 PM revealed that the client received Zyprexa 15 mg to manage behaviors. Review of the current physician orders also indicated that the client received Revia 50 mg once a day as well for the management of her behaviors.</p> <p>Review of the BSP dated December 1, 2007 address targeted behavior of screaming, self-injurious behavior (finger bending) and trichotillomania. The BSP incorporated psychotropic medications to include Zyprexa and Clonazepam (anticonvulsant), however did not include Revia.</p>	W 262			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 262	Continued From page 14	W 262			
W 263	<p>Review of the HRC minutes on December 20, 2007 revealed that the client's BSP was review and approved by the HRC, however Revia psychotropic medication was not approved as a behavior intervention. Revia was added to the client's psychotropic regime on May 4, 2007.</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for one of the three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>The facility failed to obtain informed consent prior to the use of restrictive measures as described in Client #2's Behavior Support Plan and sedation. [See W124]</p>	W 263			
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by:</p>	W 331			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	Continued From page 15 Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with client needs, for one of the three clients residing in the sample. (Client #3) The finding includes: 1. The facility's nursing staff failed to ensure that Client #3's self medication assessment accurately describes the clients capabilities as evidenced below: During the medication pass observation conducted on December 18, 2007 at 7:19 PM, Client #3 received her medication by mouth. Review of the Self Medication Assessment dated March 6, 2007 indicated that the client the following: "all meds to be administered via G-tube." Interview with the facility's nurse on December 20, 2007 revealed that the physician indicated that the client can receive her medications by mouth and that if she refused them then the medication could be given via the G-tube, however there was no evidence that the client had been re-assessed by the nursing staff nor had the client's self-medication assessment been updated to reflect the clients ability to accept her medications per mouth. 2. The facility's nurse failed to use the recommended adaptive equipment during the medication administration for Client #3. [See W192]	W 331			
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 369	Continued From page 16 This STANDARD is not met as evidenced by: Based on observation, and record review, the facility failed to ensure that the client received prescribed medications without error for one of the three clients in the sample. (Client #2) The finding includes: During the medication pass observation conducted on December 18, 2007 at 6:15 PM, the nurse administered Advair and Combivent nebulization treatments to Client #2. Both medications were administered via an inhaler. The nurse placed the inhaler near the clients mouth and gave a puff of medication, however, the puff was not synchronized with the clients taking a breath in (inhaling). It could not be determined if the medication reached the clients lung as intended.	W 369			
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility to furnish and maintain eyeglasses and furnish a hearing aid for one of the three clients included in the sample. (Client #2)	W 436			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 436	<p>Continued From page 17</p> <p>The findings include:</p> <p>1. The facility failed to furnish, maintain in good repair, and teach Client #2 to use and clean her eyeglasses.</p> <p>During the survey, the client was not observed wearing eyeglasses. Review of the Client #2's medical record on December 19, 2007 revealed an ophthalmology consult dated January 7, 2007. The consultation form indicated that the client wore prescription eyeglasses. Interview with the direct care staff, Facility Coordinator and day nurse indicated that the client wore eyeglasses and the client broke them within the last month. Review of the Health Care Management Plan (HCMP) on December 19, 2007 dated November 7, 2007 revealed that the client had a diagnosis of myopia. The HCMP recommended staff to encourage the client to wear her eyeglasses and assist with maintenance and cleanliness of eyeglasses.</p> <p>According to the Individual Program Plan (IPP) dated November 7, 2007 there was no training program in this domain.</p> <p>2. The facility failed to furnish Client #2 with a hearing aid as recommended.</p> <p>Review of Client #2's medical record on December 19, 2007 revealed a HCMP dated November 7, 2007 with a diagnosis of hearing impaired. According to the an audiometry consultation dated November 14, 2007 recommended an amplification for the client's bilaterally hearing loss. Interview with the Developmental Disability Services Case Manager on December 20, 2007 indicated that the client</p>	W 436			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 436	Continued From page 18 had been in need of a hearing aid for at least the past two years from a previous provider. At the time of th survey, the client had not obtained the recommended hearing aid.	W 436			
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on December 18, 2007 at approximately 3:00 PM revealed the following staffing schedule: 1st Shift 6 AM to 2:30 PM 2nd Shift 2 PM to 10:30 PM 3rd Shift 10 PM to 6:30 AM Weekends 1st 6 AM to 6 PM Further interview with the QMRP revealed that the staff was required to conduct one drill per month on each shift. Review of the fire drill log book revealed that the facility failed to hold evacuation drills at least quarterly for each shift as evidenced below: a. January 2007 through March 2007, no drills were held on the first shift on the weekends, and	W 440			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 440	Continued From page 19 the third shift during the week. b. July 2007 through September 2007, no drills were held on weekend shift and the second and third shift during the week. c. October 2007 through December 18, 2007, no drill were held on the third shift during the week. The Qualified Mental Retardation Professional achknnowledged no quarterly fire drills.	W 440			
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, the facility failed to implement infectious control procedures to prevent communicable infectious diseases for one of the three clients in the facility. (Client #2) The finding includes: The facility failed to ensure that Client #2 washed her hands prior assisting with dinner preparations. On December 18, 2007 at 4:50 PM, direct care staff was observed escorting Client #2 to the kitchen to assist with dinner preparations. Once in the kitchen, the client assisted direct care staff with pouring water into cups. At no time did the staff direct the client to wash her hands prior to assisting with the meal preparations.	W 455			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	<p>INITIAL COMMENTS</p> <p>A re-licensure survey was conducted from December 18, 2007 through December 20, 2007. The survey was initiated using the fundamental survey process. A random sample of three residents were selected from a population of six females with various degrees of disabilities.</p> <p>The findings of this survey were based on observations at the group home, two day programs, interviews with residents and staff at both the group home and day programs, review of clinical and administrative records to include the facility's unusual incident reports.</p>	I 000		
I 055	<p>3502.13 MEAL SERVICE / DINING AREAS</p> <p>Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the failed to train staff in the use of proper feeding procedures for three of the three residents in the sample. (Resident's #1, #2, and #3)</p> <p>The finding includes:</p> <p>1. The facility failed to implement feeding protocols for two of the three residents in the sample. (Residents #1 and #2)</p> <p>a. On December 18, 2007 at approximately 5:10 PM, Resident #1 was observed being fed by direct care staff. The direct care staff interchangeable feeding the resident food and</p>	I 055		

Health Regulation Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

YV2911

If continuation sheet 1 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 055	<p>Continued From page 1</p> <p>liquids during the meal. The resident coughed during the meal. According to the Feeding Protocol dated September 12, 2007 revealed that the direct care staff, "Do not offer beverages until after meal completion."</p> <p>b. On December 18, 2007 during the dinner observation, Resident #2 was observed receiving her meal and after the resident completed her meal, the direct care staff gave the resident her liquids which included water and juice. Interview with the direct care staff indicated that the resident, Drinks all of her liquids at one time," and therefore her liquids are provided after the client completions her meal. Review of the resident's Feeding Protocol dated November 4, 2007 revealed that the resident should encouraged sips of beverage between bites and after meal completion.</p> <p>2. The facility's nurse failed to use the recommended adaptive equipment for Resident #3 as evidenced by the following:</p> <p>During the dinner observation on December 18, 2007 at 5:10 PM, Client #3 used a spout cup to drink her beverage. During the medication pass observation conducted on December 18, 2007 at 7:19 PM, the nurse administered medications to the client. After the client took the medication, the nurse gave the client water in a regular plastic cup. After all of the water was consumed from the plastic cup, the client asked for more water and the nurse gave her water in her spout cup. Review of the client's Individual Support Plan (ISP) dated March 7, 2007, revealed that the client was required to use a spout cup for consuming liquids.</p>	I 055			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER ID I		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 135	Continued From page 2	I 135		
I 135	<p>3505.5 FIRE SAFETY</p> <p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that each shift conducted a fire drill four times a year.</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on December 18, 2007 at approximately 3:00 PM revealed the following staffing schedule:</p> <p>1st Shift 6 AM to 2:30 PM 2nd Shift 2 PM to 10:30 PM 3rd Shift 10 PM to 6:30 AM</p> <p>Weekends</p> <p>1st 6 AM to 6 PM</p> <p>Further interview with the QMRP revealed that the staff was required to conduct one drill per month on each shift. Review of the fire drill log book revealed that the facility failed to hold evacuation drills at least quarterly for each shift as evidenced below:</p> <p>a. January 2007 through March 2007, no drills were held on the first shift on the weekends, and the third shift during the week.</p> <p>b. July 2007 through September 2007, no drills</p>	I 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 135	Continued From page 3 were held on weekend shift and the second and third shift during the week. c. October 2007 through December 18, 2007, no drill were held on the third shift during the week. The Qualified Mental Retardation Professional achknowledged no quarterly fire drills.	I 135			
I 184	3508.5(a) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (a) All major components of the administering agency or the roles of individuals when the licensee is not an agency; This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request of management staff, the GHMRP failed to provide an organizational chart depicting titles and responsibilities. The finding includes: An organizational chart was requested at the entrance conference on December 18, 2007 at 9:15 AM. This surveyor was not provided a copy of the organizational chart .	I 184			
I 185	3508.5(b) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (b) The personnel in charge of the program components;	I 185			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 185	Continued From page 4 This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request of management staff, the GHMRP failed to provide an organizational chart depicting titles and responsibilities. The findings include: An organizational chart was requested at the entrance conference on December 18, 2007 at 9:15 AM. This surveyor was not provided a copy or the organizational chart throughout the survey to determine persons in charge of the program components.	I 185		
I 186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff, and... This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request of management staff, the GHMRP failed to provide an organizational chart depicting categories and numbers of supportive and direct care staff. The finding includes: An organizational chart was requested at the entrance conference on December 18, 2007 at 9:15 AM. This surveyor was not provided a copy or the organizational chart throughout the survey to determine the categories and numbers of supportive and direct care staff.	I 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 187	Continued From page 5	I 187		
I 187	<p>3508.5(d) ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall have an organization chart that shows the following:</p> <p>(d) The lines of authority.</p> <p>This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request made of management staff, the GHMRP failed to provide an organizational chart depicting the lines of authority.</p> <p>The finding includes:</p> <p>An organizational chart was requested at the entrance conference on December 18, 2007 at 9:15 AM. This surveyor was not provided a copy or the organizational chart throughout the survey to determine the lines of authority.</p>	I 187		
I 203	<p>3509.3 PERSONNEL POLICIES</p> <p>Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter.</p> <p>The finding includes:</p> <p>Review of the personnel files conducted on December 20, 2007 at approximately 12:20 PM revealed the GHMRP failed to provide evidence</p>	I 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 203	Continued From page 6 the supervisor discussed the contents of the job descriptions with the following staff: S#1, #3, #14 and #15.	I 203		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The findings include: Review of the personnel files conducted on December 20, 2007 at approximately 12:20 PM revealed the GHMRP failed to provide evidence of current current health certificates for two of twelve direct care staff (S #1 and S #10), one Registered Nurse, One Licensed Practical Nurse (LPN #1) and the psychiatrist.	I 206		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited	I 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	<p>Continued From page 7</p> <p>to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;</p> <p>This Statute is not met as evidenced by: Based on review of training documents, the GHMRP failed to provide evidence to validate staff training as indicated by residents' need for three of the three residents in the sample. (Residents #1, #2, and #3)</p> <p>The findings include:</p> <p>The facility failed to implement feeding protocols for two of the three clients in the sample. (Clients #1 and #2)</p> <p>a. On December 18, 2007 at approximately 5:10 PM, Client #1 was observed being fed by direct care staff. The direct care staff interchangeable feeding the client food and liquids during the meal. The client coughed during the meal. The Feeding Protocol dated September 12, 2007 instructed the direct care staff, "Do not offer beverages until after meal completion."</p> <p>b. On December 18, 2007 during the dinner observation, Client #2 was observed receiving her meal and after the client completed her meal, the direct care staff gave the client her liquids which included water and juice. Interview with the direct care staff indicated that the client, Consumes all of her liquids at one time," and therefore her liquids were provided after the client completions her meal. Review of the client's Feeding Protocol dated November 4, 2007 required the staff to encourage sips of beverage between bites and after meals.</p> <p>2. The facility's nurse failed to use the</p>	I 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	Continued From page 8 recommended adaptive equipment for Client #3 as evidenced by the following: During the dinner observation on December 18, 2007 at 5:10 PM, Client #3 used a spout cup to drink her beverage. During the medication pass observation conducted on December 18, 2007 at 7:19 PM, the nurse administered medications to the client. After the client took the medication, the nurse gave the client water in a regular plastic cup. After all of the water was consumed from the plastic cup, the client asked for more water and the nurse gave her water in her spout cup. Review of the client's Individual Support Plan (ISP) dated March 7, 2007, revealed that the client was required to use a spout cup for consuming liquids.	I 229		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident 's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident 's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents for one of the four residents in the sample. The finding includes: Review of the facility's unusual incident reports and investigations on October 2, 2007 at	I 374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 374	Continued From page 9 approximately 8:20 AM, revealed evidence that the facility failed to notify family members immediately of the following significant incidents: a. On April 11, 2007, Resident #2 was taken to the local emergency room for shortness of breath. The resident was admitted and discharged on May 2, 2007. b. On March 17, 2007, the direct care staff discovered a "red and dark spot" on Resident #2's left heel during evening shower. The nurse assessed the resident and there were no distress noted. c. On February 22, 2007, Resident #2 was taken to the local emergency room for shortness of breath. The resident was admitted and discharged on February 27, 2007.	I 374		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview record review, the GHMRP failed to ensure the Department of Health, was notified of unusual incidents or events that substantially interfered with each resident's health	I 379		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 379	<p>Continued From page 10</p> <p>and welfare within twenty-four hours or the next work day.</p> <p>The finding includes:</p> <p>Review of the incident reports on December 18, 2007 beginning at 9:35 AM revealed the following incidents had not been reported to the State Agency as required:</p> <p>a. On April 11, 2007, Resident #2 was taken to the local emergency room for shortness of breath. The resident was admitted and discharged on May 2, 2007.</p> <p>b. On March 17, 2007, the direct care staff discovered a "red and dark spot" on Resident #2's left heel during evening shower. The nurse assessed the resident and there were no distress noted.</p> <p>c. On February 22, 2007, Resident #2 was taken to the local emergency room for shortness of breath. The resident was admitted and discharged on February 27, 2007.</p>	I 379			
I 405	<p>3520.7 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure professional services had been provided in accordance with</p>	I 405			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 405	Continued From page 11 each resident's needs for one of the three residents in the sample. (Resident #2) The findings include: 1. Review of Client #2's clinical records at the day program on December 18, 2007 at 11:20 AM revealed an Individual Support Plan (ISP) dated November 1, 2006. Interview with the Day Program Case Manager indicated that the day program had not yet received the new ISP. However, an ISP meeting was held in early November 2007. Further interview with the Developmental Disability Services (DDS) Case Manager indicated that the ISP had not yet been approved. After the DDS Case Manager approves the ISP, she would then forward the ISP to the day program. 2. Review of Client #2's clinical records from the day program on December 18, 2007 at 11:20 AM revealed incidents of finger bending, screaming and skin pinching. Interview with the day program staff revealed that the client displays maladaptive behaviors of finger bending. Further interview revealed that the day program staff were baselining these maladaptive behaviors. The baseline behaviors began documentation since June 2006. According to the DDS Case Manager on December 20, 2007, she was not aware that the day program had not developed and implemented the Behavior Support Plan as recommended at the annual ISP meeting dated November 7, 2007.	I 405		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.	I 422		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 422	<p>Continued From page 12</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan for one of three residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>1. During the entrance conference on December 18, 2007 at 9:15 AM with the Licensed Practical Nurse (LPN) revealed that Client #2 attends day program, part time (Monday, Wednesday and Fridays). On December 18, 2007 between 4:00 PM and 6:00 PM, the client walked around the facility two times. On December 20, 2007 from 9:00 AM through 1:00 PM, Client #2 was observed in her bedroom (in the bed or wheelchair) participating in active treatment of self stimulatory activities.</p> <p>Interview with the direct care staff on December 19, 2007 at approximately 11:00 AM indicated that the client had a walking program to increase endurance. Review of the client's Individual Program Plan (IPP) dated November 7, 2007 revealed an objective which stated, "[the client] will ambulate two trips around the interior of the house every hour between 7 AM - 8 PM on an ongoing basis. There was no evidence that the facility implemented Client #2's walking program as indicated.</p> <p>2. On December 18, 2007 at 5:20 PM, after Client #2 completed her dinner meal, the client was observed to remove her dinner plate and cup from the table and put on the kitchen counter with direct care staff encouragement. The direct care</p>	I 422			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	<p>Continued From page 13</p> <p>staff wiped the dining room table down. Interview with the direct care staff indicated that the client enjoyed assisting the staff. Review of the client's IPP dated November 7, 2007 revealed a program objective which stated, "Given verbal directives, [the client] will clean her areas of the table after dinner on 80% of the trials recorded per month for six consecutive months by November 2008". According to the data sheet, the steps consisted of collecting plate and utensils, taking them to kitchen, collecting paper towels, wiping the table and trashing the paper towel. The direct care staff did not encourage the client to complete all the steps to complete the task.</p> <p>3. On December 18, 2007 at approximately 4:30 PM, the direct care staff was observed preparing dinner which consisted of baked beans, coleslaw and ribs. At 4:50 PM, Client #2 was escorted by staff to the kitchen to assist with dinner preparations. Once in the kitchen, the client assisted direct care staff with pouring water into cups.</p> <p>Interview with the direct care staff indicated that the Client #2 liked to assist with dinner preparations (making salad). Review of the clients IPP dated November 7, 2007 revealed a program objective which stated, "Given verbal directives, [the client] will assist by preparing vegetable salad during dinner meal on 80% of the trials recorded per month for six consecutive month by November 2008". Further interview with the the direct care staff indicated that when a salad was not on the menu, the client would "just" assist in the kitchen. It should be noted that the data sheet indicated that the program objective should be implement and documented five times per week (Monday - Friday). There was no evidence that the facility implemented Client #2's</p>	I 422		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 14 program as indicated.	I 422		
I 424	<p>3521.5(a) HABILITATION AND TRAINING</p> <p>Each GHMRP shall make modifications to the resident 's program at least every six (6) months or when the client:</p> <p>(a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan;</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to make modifications to the residents's program at least every six months when the resident has successfully completed an objective identified in the Individual Program Plan for one of the three residents in the sample. (Resident #12)</p> <p>The finding includes:</p> <p>The facility's QMRP failed to revise Client #1's program objectives.</p> <p>Client #1's IPP dated march 7, 2007 was reviewed on December 19, 2007 at approximately 1:30 PM. The client had a program objective which stated, "Given hand over hand assistance, [the client] will activate a tape recorded (low tech device) in response to query with 70% accuracy per session for three consecutive months as measured by active treatment documentation. Record verification of the data sheets indicated that the client achieved the established criteria in July 2007.</p>	I 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 441	Continued From page 15	I 441		
I 441	<p>3521.7(k) HABILITATION AND TRAINING</p> <p>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:</p> <p>(k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment);</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure the habilitation of its residents included training in the area of mobility for one of the three residents in the facility. (Resident #2)</p> <p>The finding includes:</p> <p>1. During the entrance conference on December 18, 2007 at 9:15 AM with the Licensed Practical Nurse (LPN) revealed that Client #2 attends day program, part time (Monday, Wednesday and Fridays). On December 18, 2007 between 4:00 PM and 6:00 PM, the client walked around the facility two times. On December 20, 2007 from 9:00 AM through 1:00 PM, Client #2 was observed in her bedroom (in the bed or wheelchair) participating in active treatment of self stimulatory activities.</p> <p>Interview with the direct care staff on December 19, 2007 at approximately 11:00 AM indicated that the client had a walking program to increase endurance. Review of the client's Individual Program Plan (IPP) dated November 7, 2007 revealed an objective which stated, "[the client] will ambulate two trips around the interior of the house every hour between 7 AM - 8 PM on an ongoing basis. There was no evidence that the</p>	I 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 441	<p>Continued From page 16</p> <p>facility implemented Client #2's walking program as indicated.</p> <p>2. On December 18, 2007 at 5:20 PM, after Client #2 completed her dinner meal, the client was observed to remove her dinner plate and cup from the table and put on the kitchen counter with direct care staff encouragement. The direct care staff wiped the dining room table down. Interview with the direct care staff indicated that the client enjoyed assisting the staff. Review of the client's IPP dated November 7, 2007 revealed a program objective which stated, "Given verbal directives, [the client] will clean her areas of the table after dinner on 80% of the trials recorded per month for six consecutive months by November 2008". According to the data sheet, the steps consisted of collecting plate and utensils, taking them to kitchen, collecting paper towels, wiping the table and trashing the paper towel. The direct care staff did not encourage the client to complete all the steps to complete the task.</p> <p>3. On December 18, 2007 at approximately 4:30 PM, the direct care staff was observed preparing dinner which consisted of baked beans, coleslaw and ribs. At 4:50 PM, Client #2 was escorted by staff to the kitchen to assist with dinner preparations. Once in the kitchen, the client assisted direct care staff with pouring water into cups.</p> <p>Interview with the direct care staff indicated that the Client #2 liked to assist with dinner preparations (making salad). Review of the clients IPP dated November 7, 2007 revealed a program objective which stated, "Given verbal directives, [the client] will assist by preparing vegetable salad during dinner meal on 80% of the trials recorded per month for six consecutive</p>	I 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2007
NAME OF PROVIDER OR SUPPLIER I D I		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 441	Continued From page 17 month by November 2008". Further interview with the the direct care staff indicated that when a salad was not on the menu, the client would "just" assist in the kitchen. It should be noted that the data sheet indicated that the program objective should be implement and documented five times per week (Monday - Friday). There was no evidence that the facility implemented Client #2's program as indicated.	I 441			
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each clients rights. The findings include: See Federal Deficiency Report - Citations W124, W262, W263	I 500			